DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

TRANSMITTAL NUMBER	STATE
92-18	Missouri

PROGRAM IDENTIFICATION: Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROPOSED EFFECTIVE DATE: September 1, 1992

TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

FEDERAL REGULATION CITATION: 42 CFR 447

NUMBER OF THE PLAN SECTION OR ATTACHMENT	NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 4.19-D pages 52-71	Attachment 4.19-D pages 52-71

SUBJECT OF AMENDMENT
Updating provisions of Prospective Reimbursement Plan for NOnstate Operated Facilities for ICF/MR Services. This amendment proposes the continuatjion of FY-92 trend factor, workers' compensation and heavy care incentive adjustments. It also includes the FY-93 trend factor adjustment.

GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ZP
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

SIGNATURE OF STATE AGENCY OFFICIAL

TYPED NAME: Gary J. Stangler

TITLE: Director, Depatment of Social Services

DATE: 9/29/92

RETURN TO:
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102-6500

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 09/30/92
DATE APPROVED: JUN 06 2001

PLAN APPROVED – ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: Thomas W. Lenz

TITLE: Associate Regional Administrator for Medicaid & State Operations

REMARKS:

SPA CONTROL
Date Submitted 9/29/92
Date Received 9/30/92

cc: Martin/Vadner/Waite/CO

C. The cost base for the June 30th per-diem rate except as specified in this rule.

(E) Rate Adjustments. The department may alter a facility's per-diem rate based on --

1. Court decisions;

2. Administrative Hearing Commission decisions; or

3. Determination through desk audits, field audits and other means, which establishes misrepresentations in and/or the inclusion of unallowable costs in the cost report used to establish the per-diem rate. In these cases the adjustment shall be applied retroactively; and

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. FY-92 Trend Factor and Workers' Compensation. All facilities with either an interim rate or a prospective per-diem rate in effect on September 1, 1992 shall be granted an increase to their per-diem rate effective September 1, 1992 of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the workers' compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per-diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/MR facilities.

B. FY-93 Negotiated Trend Factor. All facilities with either an interim rate or prospective per-diem rate in effect on September 1, 1992 shall be granted an increase to their per-diem rate effective September 1, 1992 of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per-diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/MR facilities.

C. Prospective Payment Adjustment (PPA). A Fiscal Year 1992 PPA will be provided prior to the end of the state fiscal year for non-state operated ICF/MR facilities with a current provider agreement on file with the Division of Medical Services as of October 1, 1991.

(I) For providers which qualify the PPA shall be the lessor of -

(a) The provider's Facility Peer Group Factor (FPGF) times the Projected Patient Days (PPD) covered by the adjustment year times the Prospective Payment Adjustment Factor (PPAF) times the non-state operated Intermediate Care Facility for the Mentally Retarded Ceiling (ICFMRC) on October 1, 1991, FPGF x PPD x PPAF x ICFMRC. For example: A provider having 920 (nine hundred twenty) paid days for the period May, 1991 to July 1991 out of a total paid days for this same period of 28,561 (twenty eight thousand five hundred sixty one) represents a FPGF of 3.22% (three and twenty two hundredths percent). So using the FPGF of 3.22% (three and twenty two hundredths percent) x 114,244 (one hundred fourteen thousand two hundred forty four) x 24.5% (twenty four and five tenths percent) x $156.01 (one hundred

fifty six dollars and one cent) = $140,659 (one hundred forty thousand six hundred fifty nine dollars); or

(b) The provider FPGF times 145% (one hundred forty five percent) of the amount credited to the Intermediate Care Revenue Collection Center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF - is determined by using each ICF/MR facility's paid days for the service dates in May, 1991 through July, 1991 as of September 20, 1991 divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

(III) ICFMRC - is $156.01 (one hundred fifty six dollars and one cent) on October 1, 1991.

(IV) PPAF - is equal to 24.5% (twenty four and five tenths percent) for Fiscal Year 1992 which includes an adjustment for Economic Trends.

(V) PPD - is the projection of 114,244 (one hundred fourteen thousand two hundred forty four) patient days made on October 1, 1991 for the adjustment year.

(F) Rate determination shall be based on a determination of reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level of care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require such uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined by the advisory committee with the consent of the director.

(7) Allowable Cost Areas

(A) Compensation of Owners

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the services are actually performed and are necessary services.

2. Compensation shall mean the total benefit, within the limitations set forth in this plan, by the owner of the services s/he renders to the facility including direct payments for managerial, administrative, professional and other services, amounts paid by the provider for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. Reasonableness of compensation may be determined by reference to or in comparison with compensation paid for comparable institutions or it may be determined by the other appropriate means such as the Medicare and Medicaid Provider Reimbursement Manual (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this plan.

(C) Depreciation

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of:

(a) the book value of the provider;

(b) fair market value at the time of acquisition;

(c) the recognized IRS tax basis;

(d) in the case of change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid program and the facility in ratio to Medicaid recipient reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight line method. The depreciation method used for an asset under the Medicaid program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be in accordance with the American Hospital Association's guidelines. Component part depreciation is optional and allowable under this plan.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price,

historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph (7)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other Federal or state law or regulation such as Certificate of Need.

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and capital improvements and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims and necessary and proper for the operation, maintenance or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (7)(C), the interest associated with the portion of the loan or loans which exceed the asset cost basis as defined in subsection (7)(C) shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

10. A provider shall amortize finance charges, prepaid interest and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs excluding finder's fees incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if such capital expenditure fails to comply with other federal or state law or regulations such as Certificate of Need.

(E) Rental and Leases

1. Rental and leases of land, buildings, furnishings and equipment are allowable cost areas provided that the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and lease amounts, except in the case of related parties which is subject to other provisions of this plan, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to Certificate of Need approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program, shall be a non-allowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing or refunding operations such as taxes on the issuance of bond, property transfer, issuance or transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land which represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which is not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment (FICA) taxes applicable to individual proprietors, partners or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compensation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities shall also be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost area, provided that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(I) Fringe Benefits

1. Life Insurance

A. Types of insurance which are not considered an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where, insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction, and upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area --

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.

2. Retirement Plans

A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners and proprietors of the provider shall be allowable cost areas. Interest income from funded pensions or retirement plans shall be excluded from consideration in determining the allowable cost area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred Compensation Plans

A. Contributions for the benefit of employees, excluding stockholders, partners and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amount paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include travel costs incidental thereto but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stockholders; and fees paid to states of incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off such costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five (5)-year period prior to his entry into the program and has properly capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty (60)-month period.

6. For change in ownership, after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs which are reasonable, appropriate and helpful in developing, maintaining and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods or services obtained elsewhere. In the uniform cost report a provider shall identify suppliers related to it and the type-quantity, and costs of facilities, goods and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/MR is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of Title XIX recipient. Utilization review costs incurred for Title XVIII and XIX must be apportioned on the basis of reimbursable recipient days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%) the following cost centers will be calculated as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general and administrative and plant operation costs. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Nonreimbursable Costs

1. Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and Medicaid must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of social services provided under contract or subcontract is specifically excluded as an allowable item.

6. Any costs of litigation or attorneys' fees incurred by a provider of service shall not be a reimbursable cost except to the extent permitted by this part or other specific provisions of the regulation. Cost of litigation against the state, including attorneys' fees, when the litigation is reasonably related to the care of recipients and the provider prevails, are reimbursable costs. Attorneys' fees incurred in labor negotiations, and labor disputes are reimbursable. All of the attorneys' fees except those allowed by specific provisions of this regulation are non-reimbursable costs.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost, and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue; income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than recipients; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this regulation. Failure to separately account for any of the foregoing specifically set out previously in this rule in a readily ascertainable manner shall result in termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided such interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider, paragraph (7)(R)3. of this section, shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds -

A. Restricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes and income from endowments, which must be used only for a specific purpose designated by the donor. Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to re-restrict restricted funds designated by the donor for paying operating costs, the funds will not be offset from total allowable expenses.

B. Unrestricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

C. Transferred funds as used in this rule are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local or local-to-local provider. These funds are not considered a grant or gift for reimbursement purposes, thereby having no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to Medicaid Recipient Residents

1. A provider's allowable cost areas shall be apportioned between Medicaid program recipient residents and other patients so that the share borne by the Medicaid program is based upon actual services received by program recipients.

2. To accomplish this apportionment, the ratio of recipient residents' charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for Medicaid program recipient residents determined on the basis of a separate average cost per-diem for general routine care areas or at the option of the provider on the basis of overall routine care area.

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing these services.

4. Average cost per-diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

5. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this regulation, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a recipient is away from the facility on a facility sponsored group trip and remains under the supervision and care of facility personnel.

6. ICF/MR facilities that provide Intermedicare Care Services to Medicaid recipients may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities as management services, dietary, housekeeping, building maintenance and laundry.

7. In no case may a provider's allowable costs allocated to the Medicaid program include the cost of furnishing services to persons not covered under the Medicaid program.

(S) Return on Equity